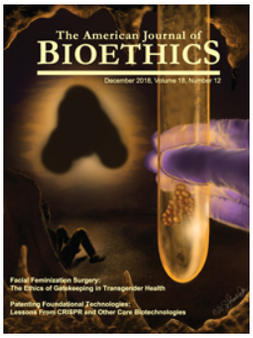

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The Biopolitics of Passing and the Possibility of Radically Inclusive Transgender Health Care

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The Biopolitics of Passing and the Possibility of Radically Inclusive Transgender Health Care

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> For them, the decision to have cosmetic surgery is described as a way to become 'ordinary', 'normal'—'just like everyone else'. Based on these stories, I concluded that it makes more sense to frame cosmetic surgery as an intervention in identity—that is, a person's sense of her embodied self—than as a beauty practice. (Davis 2003, 74)

> She isn't passing; she is merely being. (Mock 2014, 155)

Dubov and Fraenkel (2018) advocate for increased access to facial feminization surgery (FFS) as part of affirmative care for trans individuals. We concur that surgical interventions are, for many trans people, contingent elements of affirmative care. Their argument turns upon the logic (1) that passing is a requisite for trans individuals' well-being and ability to "successfully function in American society," and (2) that passing (and therefore well-being) is at least partially contingent upon medical treatments and surgeries that are "required to meet this goal" (Dubov and Fraenkel 2018, 5). We draw upon queer, feminist, and transgender theories of biomedicalization (Clarke et al. 2010; Davis 2003) to interrogate the assumptions on which Dobov and Fraenkel's advocacy for FFS surgery rests. We underscore the urgency of Dubov and Fraenkel's proposal and try to imagine an arguably more expansive vision of transgender health care that is affirming of diverse gender orientations, performances, embodiments, and identifications. Accordingly, we offer a genderqueer reading of Dubov and Fraenkel's argument in the interest of catalyzing creative, antinormative bioethical discourse on what radically inclusive (Bain et al. 2016) health care for transgender and gender nonconforming (TGNC) individuals looks like both with and beyond biomedical interventions.

We begin from the position that all technologies are scripted with meanings that can be rehearsed or undermined by uses and users (Akrich 1992). Like other forms of surgical body modification, FFS is scripted with meanings that Dubov and Fraenkel elaborate: "FFS is undertaken to produce femaleness," whereby femaleness is literally shaped by the contours and textures of the face. Rather than a "cosmetic" intervention, Dubov and Fraenkel identify FFS as a "medical necessity." Modifications to the genitals are for intimate relationships, whereas Dubov and Fraenkel suggest that FFS is for everyone else: the quotidian interactions that constitute ordinary social encounters. In this framework, FFS is an exceptionally social biomedical intervention. Users

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who "desire" it need it to function in society. In terms of feminist biomedicalization theory (Clarke et al. 2010), Dubov and Fraenkel's FFS eschews the sickness paradigm of (earlier) cissexist approaches to transgender identity in exchange for a health promotion frame.[1] According to the relevant research, the outcomes of FFS are self-evident insomuch as transwomen who have the surgery report "improvement in overall appearance congruence and body image satisfaction," as well as "protection from violence and discrimination," and reduced risk for depression and suicide. Dubov and Fraenkel are unequivocal in their assertion that FFS can produce passing, scripting FFS with profoundly interactive capacities—the ability to camouflage transgender women and enable instrumental negotiation of cissexism's violence.

The distinction between cosmetic and "necessary" surgeries is an ethical and epistemic one that reproduces rather than interrogates the ways that gender as a system of power co-produces the biomedical technoscience of FFS. Davis's (2003) incisive scholarship exposes how even surgical interventions that are viewed as frivolous and superficial involve identity work, including fundamental transformations of how individuals experience their bodies and selves. A critical ethics of transgender health care must likewise account for the ways in which medical choices that are at once deeply personal and subjective are likewise negotiated in institutional and social contexts that are deeply cissexist and hostile to gender nonconformity. Conservative politicians routinely produce moral panics over transgender individuals' mere existence, even going so far as to criminalize use of public restrooms that correspond with one's gender identity (versus sex assigned at birth); absent criminalization, gender-exclusive spaces create daily threats of violence and even death for TGNC people. Hypersurveillance and restricted access to public space make up the social context in which decisions to engage in surgical body modification take place. Pervasive cissexism is likewise the context in which medical professionals and insurance providers make decisions about who should have FFS and what successful outcomes look like. The risks of everyday life as a TGNC person and the social norms of cissexism—as well as racist and heterosexist beauty norms—may compel trans individuals into complex "choices" about surgery; for example, one study found that more nearly 50% of trans individuals "aren't sure" whether they want sexual reassignment surgery in the future (James et al. 2016). Decisions about surgery are often more straightforward for binary-identified trans individuals (i.e., transwomen and transmen), while genderqueer individuals may have a more difficult time finding transition steps that affirm their identities, because health care providers may only be prepared to discuss and implement options that reflect binary-aligned transition steps (Koehler et al. 2018). Accordingly, we position FFS as a politically fraught practice that has obviously liberatory potentials, as well as the capacity to buttress cissexist social forces that violently reject gender nonconformity.

The transgender umbrella includes people whose gender does not align with their sex assigned at birth, people who do not conform to cisgender and heterosexual societal expectations, and people who use other labels (i.e., genderqueer and nonbinary people). By foregrounding the experiences of genderqueer and nonbinary individuals—who account for at least 25–35% of transgender populations (Webb et al. 2017) and who may not generally, by cissexist standards, "pass"—we suggest that the ethics of FFS should turn upon questions not only of access and inclusion, but about gender and power. Recent psychological research argues against three key assumptions of binary conceptualizations of gender: (1) birth-assigned categories do not always accurately predict gender identity, (2) individuals may identify with neither gender and instead identify as nonbinary, and (3) self-labeling of gender (i.e., "being gender") is separate from enacting gender roles, traits, and behaviors (i.e., "doing gender") (Hyde et al. 2018, 9). For some transgender or nonbinary people, "doing gender" may or may not also involve engaging in body modification practices, such as FFS. We must consider the complex interplay between "being gender" and "doing gender" when considering health care policy and implementing health care for and with transgender people who are considering body modification surgeries. Some transgender and nonbinary people may engage in body modification surgeries, too, but these practices may not match cisnormative expectations. Nonetheless, these practices should be accommodated by insurance, as well as offered and affirmed by competent and affirmative clinicians.

Indeed, binary, cissexist ideas about gender can be inadvertently reinforced even in the context of intentionally affirmative transgender health care. Ansara and Hegarty (2012) found, for example, that psychologists routinely reproduce cisgenderism in research that otherwise purports to support the mental health and dignity of gender nonconforming children. Trans author and activist Janet Mock (2014) asserts "The misconception of equating ease of life with 'passing' must be dismantled in our culture. The work begins by each of us recognizing that cis people are not more valuable or legitimate and that trans people who blend as cis are not more valuable or legitimate than those who do not pass" (237). Thus, by constructing the "ability to 'pass' as the ultimate treatment goal," Dubov and Fraenkel's framing of FFS reinforces the gender binary and may implicitly delegitimize the genders of trans people who do not biomedically transition. While we emphatically reject judging trans people who undergo FFS, we are equally emphatic about the need to interrogate the institutional politics of FFS—as a biomedical, and therefore bioethical, phenomenon.

1. We use the term "cissexism" to denote systemic discrimination, prejudice, and violence directed at TGNC people; others, such as Ansara and Hegarty (2012), prefer the term "cisgenderism."

Access to FFS should be prioritized alongside a commitment to erode the social forces that cause the pain, violence, and social risks that motivate some to pursue FFS. We need to ask difficult questions about FFS and transgender health care more broadly. How do biomedical interventions like FFS subtly make cissexism the responsibility of TGNC individuals rather than the cisgender individuals who (re)produce cissexist, racist, and heterosexist norms of appearance and beauty? The model of radically inclusive queer therapy introduced by Bain et al. (2016) suggests that efforts to include or incorporate LGBT individuals into existing health care frameworks must consider how these individuals' life histories and perspectives might actually challenge existing paradigms. We encourage health care providers and health policymakers to consider how trans and nonbinary bodies and identities are discomforting to the systems and values enshrined in dominant biomedical knowledge-politics (Grzanka et al. 2016). How do FFS and passing make cisgender people more comfortable with trans people, and how can we disinvest in this comfort as we seek a radically inclusive future for trans health care? ■

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Extending Health Insurance for Body Modifications for Gender Transitions

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Alex Dubov and Liana Fraenkel (2018) refer to "medical necessity" as a legal doctrine, and they treat that doctrine as the threshold of clinical services "meant to be covered" by insurers. Dubov and Fraenkel then argue that certain facial modifications are medically necessary to transgender women and that, therefore, health insurers should cover those costs. The evidence on behalf of the necessity is the importance of facial modification to transgender women.

Dubov and Fraenkel do not argue in this analysis that people have right to health insurance or—for that matter—to health care more generally. That they do not matters because without some more ulterior moral foundation, both governments and private insurers have broad leeway in deciding the extent of health care they will provide. Often guided by market considerations, private insurers are free to make decisions about the treatments they pay for outright or subsidize, except as

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